MDR Tracking Number: M5-05-0565-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-15-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, electrical stimulation, therapeutic exercises, manual therapy and hot-cold pack therapy from 1-7-04 through 1-22-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-01-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Some of the EOB's indicated payment by the insurance carrier. However, on 11-29-04 the requestor stated that no additional payments had been received.

Regarding CPT code 97110 for dates of service 1-16-04, 1-28-04, 2-12-04, 1-27-04, 2-4-04, 2-6-04, 2-10-04, and 2-17-04: Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

CPT code 97140-59 for dates of service 1-16-04, 1-27-04, 1-28-04, 2-4-04, 2-6-04, 2-10-04, 2-12-04 and 2-17-04 was denied as F – The charge for this procedure exceeds the fee

schedule or usual and customary allowance. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Recommend reimbursement of $271.88 ($33.91 x 8 DOS).**

CPT code 99212 for dates of service 1-16-04, 1-27-04, 1-28-04, 2-4-04, 2-6-04, 2-10-04, 2-12-04 and 2-17-04, was denied as F – The charge for this procedure exceeds the fee schedule or usual and customary allowance or there was no denial code on the EOB. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). **Recommend reimbursement of $280.00 ($35.00 x 8).**

CPT code G0283 for dates of service 1-16-04, 1-22-04, 1-27-04, 1-28-04, 2-4-04, 2-10-04, 2-12-04 and 2-17-04, was denied as F – The charge for this procedure exceeds the fee schedule or usual and customary allowance. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Recommend reimbursement of $114.80 ($14.35 x 8 DOS**)

CPT code 99455 on 2-12-04 was denied as N – not appropriately documented. There is no evidence that the requestor provided further documentation. **Reimbursement not recommended.**

CPT code 97010 for dates of service 1-16-04, 1-22-04, 1-27-04, 1-28-04 and 2-12-04 was denied with three different denials: (F) – The charge for this procedure exceeds the fee schedule or usual and customary allowance; (N) – not appropriately documented; or (3) there was no code on the EOB. The Trailblazer Local Coverage Determination (LCD) states that code 97010 "is a bundled code and considered an Integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed." **No reimbursement recommended.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
  plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 1-16-04 through 2-17-04 as outlined above in this dispute.

This Decision and Order is hereby issued this 26th day of January 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

January 4, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-0565-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-0565-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- Letter of medical necessity
- Office notes 07/30/03 – 02/26/04
- Physical therapy notes 07/07/04 – 03/25/04
- Electrodiagnostic evaluation 12/12/02
- Radiology report 09/03/03

Information provided by Respondent:
- Correspondence
- Physician review

Information provided by Pain Management Specialist:
- Office notes 01/21/04 – 10/21/04

Information provided by Spine Surgeon:
- Office note 10/30/03

Clinical History:
The records indicate the patient was injured on ___. She sustained an injury to her right arm and neck. Since her injury, the patient has had ongoing treatment. Over the course of time, she received conservative care and physical therapy, TENS unit, massage therapy, ultrasound, chiropractic care, medication, and 4 injections. She had been scheduled surgical intervention; however, this was denied by the insurance carrier. Diagnostic testing in the form of cervical MRI's and electrodiagnostic testing confirmed this patient's injuries. Two designated doctor evaluations as well as independent medical evaluations found the patient was not at maximum medical improvement.

Disputed Services:
Electrical stimulation, therapeutic exercises, manual therapy, office visit and hot/cold pack therapy during the period of 01/07/04 thru 01/22/04.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
There is no clinical documentation to justify continuation of chiropractic care and therapy from January 7, 2004 through January 22, 2004. The records indicate there had been sufficient conservative treatment performed on this patient on the date of her injury. The patient should have been released to a home exercise program to be utilized to prevent de-conditioning until cervical spine surgery could be performed. Once surgical intervention was performed, then appropriate post-surgical rehabilitation would be in order. In conclusion, it was not medically necessary for this patient to receive electrical muscle stimulation, therapeutic exercises, manual therapy, office visits, hot/cold pack therapy from January 7, 2004 through January 22, 2004.